# COUNTY OF LOS ANGELES
## OFFICE OF THE COUNTY COUNSEL

648 KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET
LOS ANGELES, CALIFORNIA 90012-2713

DAWYN R. HARRISON
Acting County Counsel

TELEPHONE
(213) 974-1885
FACSIMILE
(213) 626-2105
TDD
(213) 633-0901
E-MAIL
abyers@counsel.lacounty.gov


November 1, 2022

**ADOPTED**
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES
86 November 1, 2022

CELIA ZAVALA
EXECUTIVE OFFICER

TO: CELIA ZAVALA
Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: ADRIENNE M. BYERS
Litigation Cost Manager
Executive Office

RE: **Item for the Board of Supervisors' Agenda**
**County Claims Board Recommendation**
**Rufino Paredes v. County of Los Angeles, et al.**
**United States District Court Case No. 21-CV-02644**

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and the Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

AMB:jkb

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Rufino Paredes v. County of Los Angeles, et al, United States District Court Case No. 21-CV-02644, in the amount of $1,900,000, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Sheriff's Department's budget.

This wrongful death lawsuit alleges federal civil rights violations, denial of medical care, and negligence arising from the death of plaintiff's son while in the custody of the Sheriff's Department.

## CASE SUMMARY

## INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

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| CASE NAME | | Paredes, Rufino, et al. v. County of Los Angeles, et al. |
| CASE NUMBER | | 21-CV-02644 |
| COURT | | United States District Court |
| DATE FILED | | March 9, 2021 |
| COUNTY DEPARTMENT | | Sheriff's Department |
| PROPOSED SETTLEMENT AMOUNT | $ | 1,900,000 |
| ATTORNEY FOR PLAINTIFF | | Steward J. Powell, Esq. |
| COUNTY COUNSEL ATTORNEY | | Millicent L. Rolon, Principal Deputy County Counsel |
| NATURE OF CASE | | This is a recommendation to settle for $1,900,000, inclusive of attorneys' fees and costs, a wrongful death and federal civil rights lawsuit filed by decedent Rufino Paredes' mother, and five minor children, by and through their guardians ad litem, following the in-custody death of Mr. Paredes.<br><br>Given the risks and uncertainties of litigation, a reasonable settlement at this time will avoid further litigation costs. The full and final settlement of the case in the amount of $1,900,000 is recommended. |
| PAID ATTORNEY FEES, TO DATE | $ | 33,889 |
| PAID COSTS, TO DATE | $ | 14,328 |

Case Name: Rufino Paredes v. County of Los Angeles, et al.

# Summary Corrective Action Plan

The intent of this form is to assist departments in writing a corrective action plan summary for attachment to the settlement documents developed for the Board of Supervisors and/or the County of Los Angeles Claims Board. The summary should be a specific overview of the claims/lawsuits' identified root causes and corrective actions (status, time frame, and responsible party). This summary does not replace the Corrective Action Plan form. If there is a question related to confidentiality, please consult County Counsel.

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| Date of incident/event: | November 29 - 30, 2018 |
| Briefly provide a description of the incident/event: | **Rufino Paredes v. County of Los Angeles**<br>Summary Corrective Action Plan 2022-18<br><br>On Thursday, November 29, 2018, at approximately 9:44 p.m., two Los Angeles County Sheriff's Department deputy sheriffs assigned to Industry Station, working as a two-person unit, responded to a vehicle theft in progress call for service at 16218 Central Avenue, La Puente, CA 91744.<br><br>As the deputies arrived at the location, they observed the described male Hispanic (the decedent) seated in the driver's seat of the vehicle (2004, Honda, License #7NPB127, green in color) in the call. The deputies noticed the front driver-side window and the rear driver-side passenger window were shattered. Also, the deputies saw the decedent leaning forward toward the ignition and appeared to be attempting to start the car with an unknown object in his hand.<br><br>The decedent was detained pending a grand theft auto investigation. At the conclusion of the investigation, it was determined the decedent did not own the vehicle nor was he given permission to be in the vehicle. It should be noted the unknown object in the decedent's hand was an altered "shaved" key.<br><br>Based on the deputies' grand theft investigation and the vehicle owner statement, the decedent was arrested for Felony Grand Theft Auto, 487(d) California Penal Code and Misdemeanor Possession of Burglary Tools, 466 California Penal Code.<br><br>The decedent was arrested without incident and mirandized while seated in the back seat of the deputies' patrol vehicle. The decedent said he understood his rights and stated, "I have nothing to talk about, I don't know what's going on."<br><br>As the decedent sat in the backseat of the patrol vehicle, his mother arrived at the scene. Deputy one heard the decedent's mother stating aloud, the decedent had a drug problem and she did not know why he would act in such a manner. At no time did deputy one hear the decedent's mother say he suffered from mental illness or had suicidal ideations.<br><br>The deputies completed their investigation and transported the decedent to Industry Station where he was booked for the indicated charges. The decedent remained silent with his head down while being driven to the station. |

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| | **Note:** The Industry Station Jail is classified as a Type I facility, used for the detention of inmates, usually pending arraignment, for not more than 96 hours after booking, excluding holidays and weekends.<br><br>At approximately 10:03 p.m., the decedent arrived at Industry Station Jail for booking and temporary housing. During the booking process, the decedent was cooperative, but at times, he was passively uncooperative as evident by his refusal to sign paperwork and/or answer questions. Deputy two conducted a pat down search of decedent; he was found to have no contraband on his person.<br><br>Deputy two completed the medical screening questionnaire and asked the decedent a series of medical history and condition questions. The medical screening questions were all checked "No" as a response to the questions, and the decedent refused to sign the form (**Exhibit A**).<br><br>**Note:** Custody Division Manual: 6-03/030.00, The Los Angeles County Unified Arrestee Medical Screening Form shall be initiated by arresting deputy/officer. This form is completed for every person who is arrested by Sheriff's Department personnel or booked into a Sheriff's Department station/facility by an outside law enforcement agency. The Behavioral Observation and Mental Health Referral form shall be completed for all inmates who answer in the affirmative to any of the following questions (**Exhibit A**):<br><br>o Do you feel suicidal or feel like hurting yourself?<br>o Did the arrestee threaten suicide or attempt during arrest?<br>o Does the arrestee's behavior or statements suggest a risk of suicide?<br><br>After the booking process was completed, the decedent was placed in the Live Scan (electronic fingerprinting) waiting room.<br><br>Prior to being Live Scanned, the decedent told the jailer he previously used methamphetamine. The jailer questioned the decedent further about his drug use, medical conditions, and if he was suicidal. The decedent replied he did not have any medical conditions, nor was he suicidal.<br><br>While the jailer Live Scanned the decedent, he remained silent and was staring at her while he was being Live Scanned. The jailer asked the decedent if he was on any medication. The decedent responded by saying, "mmmmmh noooo." Based on his behavior, the jailer believed he may have been "coming off something."<br><br>On November 30, 2018, at approximately 2:18 a.m., upon completion of being Live Scanned, the decedent was escorted to Cell E-1 (single-man cell) for housing. The decedent was provided food, a beverage, and a jail bed roll (1 sheet and 1 blanket).<br><br>**Over the next three hours, the following station jail visual checks were conducted:** |

| Time of check | Length of time between checks |
|---|---|
| 2:26 a.m. (Jailer) | 8 minutes |
| 3:04 a.m. (Jailer) | 38 minutes |
| 3.32 a.m. (Jailer) | 28 minutes |
| 4:00 a.m. (Watch Commander) | 28 minutes |
| 4:32 a.m. (Watch Sergeant) | 32 minutes |
| 5:18 a.m. (Jailer) | 46 minutes |
| 5:30 a.m. (Jailer) | 12 minutes |

**Note:** The Industry Station Jail was staffed with one full duty jailer (custody assistant). The second jailer assigned was light duty and completing paperwork in another part of the station. During the shift, there are thirty minute staggered safety checks by the jailer, two safety checks by the watch Commander, and two safety checks by the watch Sergeant on each shift.

At 5:18 a.m., a safety check was conducted and the jailer saw the decedent awake and alert and asked to use the telephone. The jailer told the decedent he would have to wait until shift change (in 45 minutes).

At 5:30 a.m., when the jailer conducted the next safety check, the decedent was seen laying on the cell floor with his head near the barred/screened gate and only his mid-back and feet were visible. A pool of blood was seen under the closed sliding barred gate.

The jailer notified the on-duty watch sergeant the decedent was apparently in need of medical attention inside his cell. The on-duty watch commander and assisting deputies responded to cell E-1.

Upon entry into cell E-1, the decedent was seen by responding deputy personnel lying face down with one end of a white bedsheet tied around his neck and the other around the base of the cell gate frame. Responding deputy three used shears from the station's Suicide Intervention Kit to cut the bedsheet from the decedent's neck. Once the bedsheet was removed from the decedent's neck, he was placed on his back (face up).

Deputy personnel monitored the decedent's vitals. Deputy three immediately began Cardiopulmonary Resuscitation (CPR) and deputy four used an Ambu bag (rescue breathing) on the decedent, pending arrival of the Los Angeles County Fire Department and paramedics.

The paramedics relieved the deputies and continued CPR on the decedent. During this incident, one of the paramedics contacted a doctor at Emanate Health Queen of the Valley Hospital (1115 South Sunset Avenue, West Covina, CA 91790) via telephone.
At 5:58 a.m., the decedent was pronounced deceased by the doctor over the phone.

At 6:00 a.m., the initial Homicide Detectives responded to Industry Sheriff's Station. At 7:30 a.m., the secondary Homicide Detectives arrived and were provided preliminary information regarding the incident and the decedent then proceeded to walk the scene.

During the investigation, the Los Angeles County Sheriff's Department's, Forensic Identification Specialist responded to Industry Sheriff's Station. The investigator documented and photographed the scene.

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| | At 1:00 p.m., the decedent's mother arrived at Industry Sheriff's Station and was advised of the incident.<br><br>At 1:11 p.m., the Los Angeles County Coroner arrived at Industry Station Jail and took custody of the decedent. The decedent was transported to the Los Angeles County Coroner's Office for further investigation. |

1. Briefly describe the **root cause(s)** of the claim/lawsuit:

A **Department** root cause in this incident was deputies one and two's failure to identify the medical necessity to take a possibly impaired suspect for a medical evaluation after being told by his family members he had a drug problem.

A **Department** root cause in this incident was deputy two answering "No" to all of the medical questions on the Arrestee Medical Screening Form, even though the decedent refused to sign and was quiet throughout the process

**Department** root cause in this incident was the exposed bar on the cell door, which allowed the decedent to affix a noose made from a bed sheet.

A **Department** root cause in this incident was cell door scanners being inoperable due to poor Wi-Fi within the Industry Station jail.

A **Department** root cause in this incident was the deputies were not equipped with Body-Worn Cameras (BWC) to record their contact with the decedent and decedent's family member, in order to prove or disprove plaintiff's allegations.

A **Department** root cause in this incident was the lack of signage "Suicide Prevention Notice" within the direct vision of the decedent.

A non- **Department** root cause in this incident was the decedent refused to answer questions asked by the deputies and did not advise the jailer of his mental state of mind.

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

**Supervisory Inquiry**
This incident was thoroughly investigated by Industry Station to determine if deputy sheriff one and two's actions were within Department policy.

Appropriate administrative actions were taken.

**Station Briefings**
This incident was thoroughly investigated and the sergeant rebriefed the Sheriff's Department's policies regarding booking prisoners, emergency panel procedures, and radio communication.

**Cell Modifications and Inmate Bedding Modification**
Since this incident, Industry Station executives reviewed and discussed the physical condition of the station jail.

Facilities Services Bureau responded to Industry Station and welded a metal plate over the pole preventing it from being used in the same manner.

The issuance of bed sheets is no longer distributed to inmates at Industry Station. In place of the bed sheet, two blankets are given upon request from the prisoner.

**Internet Connect Wi-Fi Upgrade**
At the time of this incident, electronic scanners were not being used to conduct inmate safety checks. Times of cell checks were handwritten on a log to track required checks.

Since this incident, the Wi-Fi within the jail has been upgraded and allows the jailers to electronically document the cell checks via handheld scanners.

**Body-Worn Cameras (BWC)**
As of October 2020, all personnel assigned to Industry Station were issued Body-Worn Cameras in an effort to ensure all public contact is transparent. The use of BWC's ensures reliable recording of enforcement and investigative contacts with the public. The Department established policy and procedures for the purpose, use, and deployment of the Department issued BWC.

**Station Jail Posted Signage**
Signs are posted on the outside of the cell alerting inmates who are feeling suicidal to contact a deputy sheriff for help.

Additional signs were posted on the wall opposite of the cell. The signs are printed in both Spanish and English.

3. Are the corrective actions addressing Department-wide system issues?

☐ Yes – The corrective actions address Department-wide system issues.

☒ No – The corrective actions are only applicable to the affected parties.

Los Angeles County Sheriff's Department

| Name: (Risk Management Coordinator)<br>Shawnee N. Hinchman, A/Captain<br>Risk Management Bureau | |
|---|---|
| Signature: | Date: 6/13/22 |

| Name: (Department Head)<br>Edwin E. Alvarez, Chief<br>Professional Standards Division | |
|---|---|
| Signature: | Date: 6/15/22 |

**Chief Executive Office Risk Management Inspector General USE ONLY**

Are the corrective actions applicable to other departments within the County?

☐ Yes, the corrective actions potentially have County-wide applicability.

☑ No, the corrective actions are applicable only to this Department.

| Name: (Risk Management Inspector General)<br>Destiny Castro | |
|---|---|
| Signature: Destiny Castro | Date: 06/15/2022 |